TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION
GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Tracking Number
M4-14-0130-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
September 13, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Patient has authorization for work hardening program. Carrier shall not withdraw a preauthorization or concurrent review approval once issued. Office visits are recommended as determined to be medically necessary. Medical necessity for office visits in conjunction with work status form 73... Therefore, these claims should be paid in full."

Amount in Dispute: $5,201.42

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 27, 2012 through May 16, 2013	99213 x 13 , 97140 x 5, 97112 x 5, 97110 x 5, 99080-73 x 11, 99214, 99361 x 2, 97545-WH and 97564-WH	$5,201.42	$1,815.94

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.305, sets out the Medical Dispute Resolution general guidelines.
3. 28 Texas Administrative Code §134.203, sets out the Medical Fee Guideline for Professional Services.
4. 28 Texas Administrative Code §134.600, requires preauthorization for non-emergency health care.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 219 – Based on extent of injury
   - 216 – Based on the findings of a review organization
   - PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary.
   - B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment.
   - 247 – A payment or denial has already been recommended for this service.
   - 16 – Claim/service lacks information, which is needed for adjudication.
   - 943 – 507 – Documentation does not support billed charge. No recommendation of payment can be made

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service August 28, 2012 and September 12, 2012?
2. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.305 and §133.307, for dates of service September 27, 2012 through November 5, 2012 (CPT Codes 99213 and 99080-73, November 26, 2012 through April 24, 2013 (CPT Codes 99213 and 99080-73), April 29, 2013, May 15, 2013 and May 16, 2013?
3. Are the disputed services rendered on September 27, 2012 through November 5, 2012 (CPT Codes 99213 and 99080-73, November 26, 2012 through April 24, 2013 (CPT Codes 99213 and 99080-73), April 29, 2013, May 15, 2013 and May 16, 2013 eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?
4. Did the requestor obtain preauthorization for CPT Codes CPT Codes, 97110, 97112 and 97140 rendered on September 19, 2012, November 5, 2012, November 6, 2012 and November 7, 2012?
5. Is the requestor entitled to reimbursement for CPT Codes CPT Codes, 97110, 97112 and 97140 rendered on September 19, 2012, November 5, 2012, November 6, 2012 and November 7, 2012?
6. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states, "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute."

   The dates of the service in dispute are August 28, 2012 and September 12, 2012. The request for medical fee dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) Section on September 13, 2013. These dates are later than one year after the date(s) of service in dispute. The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service August 28, 2012 and September 12, 2012?

2. The medical fee dispute referenced above contains unresolved issues of extent-of-injury for dates of service, May 15, 2013 and May 16, 2013. The insurance carrier denied/reduced the disputed services with reason code(s), "219 – Based on extent of injury." The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical bill review process.

   28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes and medical necessity disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) and §133.307(f) (3) (B) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent-of-injury dispute for the claim and if the request contains an unresolved adverse determination of medical necessity. 28 Texas Administrative Code §133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   The Division hereby notifies the requestor that for dates of service, May 15, 2013 and May 16, 2013, the appropriate process to resolve the issue(s) of extent-of-injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1.

   The medical fee dispute referenced above contains unresolved issues of medical necessity for dates of service September 27, 2012 through November 5, 2012 (CPT Codes 99213, 99214, 99361 and 99080-73), November 26, 2012 through April 24, 2013 (CPT Codes 99213, 99361 and 99080-73), April 29, 2013, May 15, 2013 and May 16, 2013 (99213 and 99080-73). The insurance carrier denied/ reduced the disputed services with reason code(s), "216 – Based on the findings of a review organization, and PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary."

   The Division hereby notifies the requestor that for dates of service September 27, 2012 through November 5, 2012 (CPT Codes 99213, 99214, 99361 and 99080-73), November 26, 2012 through April 24, 2013 (CPT Codes 99213, 99361 and 99080-73), April 29, 2013, May 15, 2013 and May 16, 2013 (99213 and 99080-73), the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review, to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may

be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

3. 28 Texas Administrative Code §133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

   The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This dismissal is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered. The Division finds that dates of service; September 27, 2012 through November 5, 2012 (CPT Codes 99213, 99214, 99361 and 99080-73), November 26, 2012 through April 24, 2013 (CPT Codes 99213, 99361 and 99080-73), April 29, 2013, May 15, 2013 and May 16, 2013 (99213 and 99080-73), are not eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307. Therefore, the medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute for these dates of service. As a result, no amount is ordered.

4. The insurance carrier denied/reduced the disputed dates of service September 19, 2012 through April 29, 2013 with denial/reduction codes, "216 – Based on the findings of a review organization, PI – These are adjustments initiated by the payer, for such reasons as billing errors or services that are considered not reasonable or necessary, B13 – Previously paid. Payment for this claim/service may have been provided in a previous payment, 247 – A payment or denial has already been recommended for this service, "16 – Claim/service lacks information which is needed for adjudication, and 943 – 507 – Documentation does not support billed charge. No recommendation of payment can be made."

   28 Texas Administrative Code §134.600 states in pertinent part, "(p) Non-emergency health care requiring preauthorization includes... (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels..."

   28 Texas Administrative Code §134.600 states in pertinent part, "(c) The insurance carrier is liable for all reasonable and necessary medical costs relating to the health care: (1) listed in subsection (p) or (q) of this section only when the following situations occur... (B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care..."

   Review of the preauthorization letter dated August 31, 2012 issued by Sedgwick CMS documents the following:

Procedure	97110, 97112 and 97140
Reference #	J565
Approved Units	3
Start Date	August 3, 2012
End Date	September 28, 2012

   The requestor seeks reimbursement for CPT Codes, 97110, 97112 and 97140 rendered on September 19, 2012. The Division finds that the services rendered on September 19, 2012 were preauthorized by the insurance carrier, as a result, the insurance carrier's denial of medical necessity is not supported and the disputed charges are eligible for review pursuant to the applicable rules and guidelines.

   Review of the preauthorization letter dated October 19, 2012 issued by Sedgwick CMS documents the following:

Procedure	97110, 97112 and 97140
Reference #	JU38
Approved Units	3
Start Date	October 16, 2012
End Date	November 16, 2012

   The requestor seeks reimbursement for CPT Codes, 97110, 97112 and 97140 rendered on November 5, 2012, November 6, 2012 and November 7, 2012. The Division finds that the services rendered on November 5, 2012, November 6, 2012 and November 7, 2012 were preauthorized by the insurance carrier, as a result, the insurance carrier's denial of medical necessity is not supported and the disputed charges are eligible for review pursuant to the applicable rules and guidelines.

Review of the preauthorization letter dated April 18, 2013 issued by Sedgwick CMS documents the following:

Procedure	Work hardening/initial 2 hrs Work Hardening x 80 hours/medically certified by RN
Reference #	MKOZ
Approved Units	80
Start Date	April 18, 2013
End Date	June 18, 2013

The requestor seeks reimbursement for CPT Codes 97545-WH, and 97546-WH rendered on April 24, 2013. The Division finds that the services rendered on April 24, 2013 were preauthorized by the insurance carrier, as result the insurance carrier's denial of medical necessity is not supported and the disputed charges are eligible for review pursuant to the applicable rules and guidelines.

5. 28 Texas Administrative Code §134.203 states in pertinent part, "(c) To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32; (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year..."

   The CMS Medicare Claims Processing Manual Publication 100-20 states, "For therapy services furnished by a group practice or "incident to" a physician's service, the MPPR applies to all services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology. The reduction applies to the HCPCS codes contained on the list of 'always therapy' services that are paid under the physician fee schedule, regardless of the type of provider or supplier that furnishes the services (e.g. hospitals, home health agencies, and comprehensive outpatient rehabilitation facilities (CORFs), etc.) The MPPR applies to the procedures in Attachment 1. Note that these services are paid with a non-facility PE. The current and proposed payments are summarized below in the following example for services furnished in an institutional setting (Note: for office and other non-institutional settings, the reduction percentage is 20 percent)."

   CPT codes 97110, 97140 and 97112 are identified as "always therapy' codes, therefore are subject to the MPPR. Reimbursement is recommended below for dates of service September 19, 2012, November 5, 2012, November 6, 2012 and November 7, 2012.

   - Procedure code 97110, service date September 19, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.44955. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.979 is 0.43076. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.88857 is multiplied by the Division conversion factor of $54.86 for a MAR of $48.75. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $44.02 at 4 units is $176.08.
   - Procedure code 97140, service date September 19, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.42957. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.979 is 0.3916. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.82943 is multiplied by the Division conversion factor of $54.86 for a MAR of $45.50. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.21 at 2 units is $82.42.

- Procedure code 97112, service date September 19, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.44955. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.979 is 0.46992. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.92773 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.90. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $50.90. The PE reduced rate is $45.74. The total is $96.64.
- Procedure code 97110, service date November 5, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.44955. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.979 is 0.43076. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.88857 is multiplied by the Division conversion factor of $54.86 for a MAR of $48.75. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $44.02 at 4 units is $176.08.
- Procedure code 97140, service date November 5, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.42957. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.979 is 0.3916. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.82943 is multiplied by the Division conversion factor of $54.86 for a MAR of $45.50. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.21 at 2 units is $82.42.
- Procedure code 97112, service date November 5, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.44955. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.979 is 0.46992. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.92773 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.90. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $50.90. The PE reduced rate is $45.74. The total is $96.64.
- Procedure code 97110, service date November 6, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.44955. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.979 is 0.43076. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.88857 is multiplied by the Division conversion factor of $54.86 for a MAR of $48.75. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $44.02 at 4 units is $176.08.

- Procedure code 97140, service date November 6, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.42957. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.979 is 0.3916. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.82943 is multiplied by the Division conversion factor of $54.86 for a MAR of $45.50. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.21 at 2 units is $82.42.
- Procedure code 97140, service date November 6, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.42957. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.979 is 0.3916. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.82943 is multiplied by the Division conversion factor of $54.86 for a MAR of $45.50. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.21 at 2 units is $82.42.
- Procedure code 97110, service date November 7, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.44955. The practice expense (PE) RVU of 0.44 multiplied by the PE GPCI of 0.979 is 0.43076. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.88857 is multiplied by the Division conversion factor of $54.86 for a MAR of $48.75. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $44.02 at 4 units is $176.08.
- Procedure code 97140, service date November 7, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.42957. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 0.979 is 0.3916. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.82943 is multiplied by the Division conversion factor of $54.86 for a MAR of $45.50. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure does not have the highest PE for this date. The PE reduced rate is $41.21 at 2 units is $82.42.
- Procedure code 97112, service date November 7, 2012, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 0.999 is 0.44955. The practice expense (PE) RVU of 0.48 multiplied by the PE GPCI of 0.979 is 0.46992. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.826 is 0.00826. The sum of 0.92773 is multiplied by the Division conversion factor of $54.86 for a MAR of $50.90. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is subject to 20% reduction of the practice expense component. This procedure has the highest PE for this date. The first unit is paid at $50.90. The PE reduced rate is $45.74. The total is $96.64.

Per 28 Texas Administrative Code §134.204 (h) "The following shall be applied to Return To Work Rehabilitation Programs for billing and reimbursement of Work Conditioning/General Occupational Rehabilitation Programs, Work Hardening/Comprehensive Occupational Rehabilitation Programs, Chronic Pain Management/Interdisciplinary Pain Rehabilitation Programs, and Outpatient Medical Rehabilitation Programs. To qualify as a Division Return to Work Rehabilitation Program, a program should meet the specific program standards for the program as listed in the most recent Commission on Accreditation of Rehabilitation Facilities (CARF) Medical Rehabilitation Standards Manual, which includes active participation in recovery and return to work planning by the injured employee, employer and payor or carrier. (1) Accreditation by the CARF is recommended, but not required. (A) If the program is CARF accredited, modifier "CA" shall follow the appropriate program modifier as designated for the specific programs listed below. The hourly reimbursement for a CARF accredited program shall be 100 percent of the MAR. (B) If the program is not CARF accredited, the only modifier required is the appropriate program modifier. The hourly reimbursement for a non-CARF accredited program shall be 80 percent of the MAR."

28 Texas Administrative Code §134.204 (h) (3) states, "For Division purposes, Comprehensive Occupational Rehabilitation Programs, as defined in the CARF manual, are considered Work Hardening. (A) The first two hours of each session shall be billed and reimbursed as one unit, using CPT Code 97545 with modifier "WH." Each additional hour shall be billed using CPT Code 97546 with modifier "WH." CARF accredited Programs shall add "CA" as a second modifier. (B) Reimbursement shall be $64 per hour. Units of less than one hour shall be prorated by 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to 8 minutes and less than 23 minutes."

The requestor billed 2 hours of a non-CARF accredited work hardening charges, CPT Codes 2 hours of 97545-WH, and 6 hours of 97546-WH, rendered on April 24, 2013. The requestor documented 8 hours of work hardening, as a result reimbursement for non-CARF accredited work hardening services is recommended at $51.20 per hour x 8 hours = $409.60. The requestor is entitled to $409.60 for CPT Codes 97545-WH and 97546-WH rendered on April 24, 2013.

6. The Division finds that the requestor is entitled to reimbursement in the amount of $1,815.94 for disputed September 19, 2012, November 5, 2012, November 6, 2012 and November 7, 2012

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,815.94.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,815.94 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 12, 2015 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.